University of Alberta

Health Promotion as Self Nurturance:

The Personal Experience of Senior Women Living on Limited Incomes

by

Heather M. Morris

A thesis submitted to the Faculty of Graduate Studies and Research

in partial fulfillment of the requirements for the degree of

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Abstract

Health promotion is increasingly being recognized as making an important contribution to the well-being of Canada's seniors as the percentage of elderly people continues to rise. Within this population, senior women are faced with health and social circumstances that may differ significantly from those of men. One such distinction is the fact that 43.4% of unattached women 65 and older live in poverty in Canada compared to 21.3% of unattached senior men (National Council of Welfare, 1997).

A negative relationship between health status and income has been demonstrated in numerous studies. Research has also shown that those living on a low income are less likely to engage in health promotion. Despite these findings, few authors have investigated the health promotion experience as described by low income individuals, particularly senior women. A qualitative, exploratory descriptive study using ethnographic methods was conducted to gain insight into the following questions: 1) What is the health promotion experience of senior women living on limited incomes and 2) How might living on a limited income affect the experience of health promotion for this group of women?

Interviews with a total of eleven senior women living on limited incomes were analyzed for the purposes of this thesis. An account of the study and its findings which address the two research questions mentioned above are presented in the following paper. A major finding of this study was that the women utilized a wide variety of 'ways of living' which are presented in the model, *Health Promotion as Self Nurturance*. Two additional points of interest were that health promotion was

perceived to be influenced by living on a low income by most participants; however, three of the participants believed that their health status and income level were unrelated. Additional data were gathered on how these women perceived and defined health, factors they saw as influencing health promotion as well as utilization of health promotion services. Such information will likely be incorporated into future publications.

The results of this study have contributed to laying the groundwork for additional research in the area of health promotion and senior women living on limited incomes. The current knowledge base related to this topic has been expanded, thereby promising to inform the practices of health professionals, program planners and policy makers who work with low income senior women.

Acknowledgments

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Introduction

The health promotion movement has continued to be recognized as a significant contributor to the well-being of Canadians since its first appearance over twenty years ago. The introduction of the document, *A New Perspective on the Health of Canadians* (Lalonde, 1974) heralded a different way of viewing health, one which placed as much emphasis (perhaps more) on personal lifestyle as it did on other determinants such as the environment, health service availability and human biology (Hamilton & Bhatti, 1996). This emphasis on behavior change continued throughout the 1970s; however, by the 1980s, two additional documents were published which would have a lasting impact on the health promotion movement: *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986) and *The Ottawa Charter on Health Promotion* (World Health Organization, Health and Welfare Canada and Canadian Public Health Organization, 1986). These documents proved to be useful in that they "... articulated the underlying principles of health promotion and proposed strategic frameworks for action" (Canadian Public Health Association, 1996, p. 1). They also brought to the forefront the need for individuals from a wide variety of societal sectors to address health promotion from a broad, socio-environmental approach (Hamilton & Bhatti, 1996). The central elements of health promotion have since been delineated: empowerment, networking, a focus on processes and interactions, holism and participation (Muller, 1988).

Health promotion continues to be influenced by those events presently of concern to members of society. As Canadians approach the end of this decade, they face lingering unemployment and poverty rates, threats to the environment as well as

the potential erosion of the current social and health care systems (Canadian Public Health Association, 1996). As a result, many believe that increased intervention should be aimed at helping those who are most directly affected by such social circumstances.

Despite these advances, the health promotion movement has had its limitations. One such difficulty is the continued emphasis on promoting the health of young families to the exclusion of older members of our society. The hiring of public health nurses whose work focuses primarily on new mothers and infants, preschoolers and school-aged children provides evidence of which age groups are of primary importance to government in respect of health promotion and disease prevention. Seniors' health promotion needs are often overlooked despite the fact that public health professionals are supposed to be working to enhance the health of the entire community in which they work. Contrary to public opinion, many seniors are keenly motivated to incorporate health promotion as a part of their daily lives. In fact, a number of studies have shown seniors to participate in health promotion to a greater extent than younger people (Barker Bausell, 1986; Walker, Volkan, Sechrist & Pender, 1988; U.S. Public Health Service and Administration on Aging, cited in Gilbert, 1986; Proshaska, Leventhal, Leventhal & Keller, 1985).

One of the major benefits of health promotion with seniors lies in its potential to prevent or slow down the onset of chronic illness. It has been said that "much of the decline in health that used to be attributed to 'normal' concomitants of aging are due to chronic illnesses stemming from unhealthy lifestyles and poor health habits rather than 'aging' itself" (Smith, 1988). It is estimated that 80% of those over the age of 65

suffer from at least one chronic health problem (Maynard, 1991; Ouslander & Beck, cited in Ruffing-Rahal, 1991). Hence, research which addresses health promotion among seniors no doubt has the potential to affect the quality of life of a great number of people. Today, there exists a group of seniors who are likely at increased risk of chronic illness due to their increased potential for longevity (Hess, 1990). This same group could benefit greatly from such health promotion programming; however, their unique health issues and needs are often overlooked: senior women.

During the past decade, health researchers have become increasingly aware of the fact that women's health experiences, including those of senior women, are quite different from those of men. In 1985 it was determined that Canadian senior women experienced hypertension at a higher rate (43%) than their male counterparts (33%) (Statistics Canada, 1990). The incidence of arthritis/rheumatism in Canada was also found to be higher for senior women, 63% of whom reported experiencing this compared to 46% of senior men (Statistics Canada, 1990). Osteoporosis is another example of a condition which primarily affects senior women and which can have debilitating, long-term consequences (Ali & Bennet, 1992). It has also been shown that senior women are more likely to report health problems than senior men despite the fact that they are less likely to be hospitalized in this country (Desjardins, 1993).

Senior women differ most significantly from senior men, however, in terms of one of the social determinants of health and health promotion. It has been said that "for the older woman, poverty is the reward for a lifetime of work" (McCracken, 1994, p. 3). An alarming 43.4% of unattached Canadian women who are age 65 and over live

in poverty (National Council of Welfare, 1997). The significance of this problem is seen when taken together with the overwhelming evidence demonstrating that income is inversely correlated with indicators of health (Brown, 1993; Moore, 1992; Foster, 1992; Guralnik & Kaplan, 1989; Maynard, 1991; Cairney & Arnold, 1996) and health promotion (Rakowski, 1993; Jensen, Counte & Glandon, 1992; Walker, Vokan, Sechrist & Pender, 1988; Norton & Wozny, 1984; Stone & Fletcher, 1986; Statistics Canada, 1995; Makuc, Freid & Kleinman, 1989; Hanner, 1987). This relationship between low income and poor health status has been discussed by the National Advisory Council on Aging, cited here by the Canadian Public Health Association (1997):

> "People who are better off financially tend to live longer, healthier lives while t hose with less money and social status are more likely to develop health problems. This relationship is particularly strong for seniors: the poorest seniors tend to have the most activity limitations ... For many seniors, these limitations result from lifelong exposure to stress, such as low incomes, poor job opportunities, and inadequate food, shelter and social supports" (p. 15).

Thus, it is evident that income is closely tied with health and health promotion. It is also clear that we are seeing a disturbing trend of widespread poverty rates among women over the age of 65. Unfortunately, the literature to date, as shall be described in the next section, is limited in its attention towards the topic of health promotion and low income senior women. In order to interpret better the above findings and effectively work with senior women living on limited incomes, we must first speak with those whose lives are directly affected by such social circumstances. With this in mind, a qualitative, exploratory descriptive research study was undertaken for the purpose of

describing the perceptions and experiences that senior women living on limited incomes have of health promotion.

Research Study

Ethnographic methods were utilized to guide this qualitative exploratory research study due to the fact that the group being sampled was viewed to be a culture by the researcher and that extensive interviews were supplemented with field notes taken during the time of the interviews. The researcher also volunteered her time for over a year at one of the centres where participants were enrolled in the study. This allowed for information received by a number of the participants to be evaluated within the context of a health promoting environment. Health promotion was defined in this study as comprising 'ways of living or things we do to maintain or improve health' and women were considered to be 'senior' if they were age 60 and over. The term 'limited incomes', at times used interchangeably with 'low income', was purposely not defined as it was important for those participating in the study to choose for themselves whether they would classify themselves as such. Those who viewed themselves as living on a limited income in this study, did in fact have incomes which ranged from $461.00 to $1116.00 per month (six out of eight reported incomes were $800-1100/month).

Nineteen women who either accessed inner city senior services or resided in the inner city of a large Canadian centre were interviewed between October 1996 and February 1997. In this study, inner city was defined as being one of eight geographical areas as determined by the city's social planning council. Of these nineteen women,

eleven stated that they lived on a limited or low income; thus it was these eleven interviews which were analyzed for the purpose of this thesis. Recruitment of participants occurred through an inner city seniors' drop-in centre, an inner city seniors' lodge, inner city senior outreach workers as well as through an inner city seniors' wellness group facilitated by a public health nurse. Information sheets were provided to all potential participants prior to the interviews (Appendix A, B, C). These sheets were reviewed at the beginning of each interview prior to asking the women to sign the consent form (Appendix D). Biographical data were collected next (Appendix E), followed by questions which elicited the participant's perceptions and experiences of health promotion (Appendix F). Additional questions were asked of nine of the eleven women who chose to participate in a second interview.

Rigor

Four criteria for rigor as outlined by Guba & Lincoln, cited by Sandelowski (1986), were adhered to in this research study: credibility, fittingness, auditability and confirmability. Credibility was protected in a number of ways. The potential threat of "going native" (Miles & Hubberman, cited in Sandelowski, 1986) was not deemed to be too serious in this study due to the fact that the researcher was volunteering at the drop-in centre only a few hours a week and was not collecting data during that time. The researcher's thoughts and feelings were recorded in a journal throughout the study in order to keep track of how entwined her own experiences became with those of the participants. Credibility was also protected by having clearly defined concepts (LeCompte & Goetz, 1982), particularly when it came to the term 'health promotion'.

The threat of not obtaining 'data adequacy' (Morse & Field, 1995) was lessened by the fact that the researcher sampled until no new information was obtained. The potential effects of history and maturation (LeCompte & Goetz, 1982) were also taken into consideration when analyzing the results of this study.

Fittingness was assured by guarding against an underrepresentation of experiences in the data (Sandelowski, 1986). This was protected by the purposive sampling that was undertaken to ensure participants were from a variety of backgrounds & experiences. Social desirability (Brink, 1991) was controlled for by getting to know participants prior to data collection and attempting to interview participants over a minimum of two sessions. The utilization of open-ended questions during interviews as well as being cognizant of not leading participants in their answers helped to protect from the threat of 'acquiescent response set' (Brink, 1991).

Auditability was achieved by leaving a clear audit trail of the researcher's initial interests in this study, the study's purpose, the researcher's thoughts and feelings as the study progressed, data collection methods and analysis techniques as well as other vital information (Sandelowski, 1986). Such a 'decision trail' was, for the most part, recorded in a log book as the study progressed and will be explained in future publications. Finally, confirmability was assured by verifying information with participants during the second interviews as well as through self-monitoring of the researcher's experiences and feelings through journal writing.

Additional details pertaining to data collection, data analysis, ethical considerations and implications for nursing are to be found in the enclosed paper,

Health Promotion as Self Nurturance: The Personal Experience of Senior Women Living on Limited Incomes. As the name suggests, this paper discusses the related literature, research study, findings and discussion of how eleven senior women living on limited incomes experience health promotion. The effects that living on a limited income has on health promotion are also discussed in this paper. It is important to state that the information contained within this paper comprises only a fraction of the data which was collected during the interviews with these eleven women. Data regarding definitions of health, perceptions of health promotion, factors affecting health promotion, who promotes the health of these women as well as health promotion service utilization will most likely be presented in future publications.

Study Limitations

It would have been preferable for more extensive participant observation to have occurred in this study in order to have derived an even broader conceptualization of the context in which health promotion occurred for these women. Interviews with secondary informants such as drop-in staff, public health nurses and family members would have added to the depth of data obtained as well. The reader of this thesis is also reminded that although the data presented by participants was in most cases confirmed with the women during their second interview, the interpretation of findings remains that of the researcher.

Future Research

The findings of this research study have helped to lay the groundwork for additional work in the area of health promotion and senior women living on limited

incomes. A replication of this study with a group of high income senior women has the potential to provide additional insight into the role that income plays in health promotion of senior women. A comparison study might also be undertaken utilizing a sample of low income senior men to further investigate the effects of gender. Finally, the researcher continually questioned over the course of the study whether the data would have been different if the sample were more culturally heterogeneous. The experience of health promotion as described by senior Aboriginal women, is one important area worth exploring in the future.

The findings reported on in the paper which is to follow indicate three major outcomes: 1) that a wide variety of 'ways of living' were utilized by these women to promote their own health, 2) low income was seen to directly and indirectly affect health promotion by most participants and 3) some of the women stated there was no direct relationship between income and health status. Such information can now be incorporated into future theorizing when investigating the interplay between low income and health promotion within the senior population.

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Health Promotion as Self Nurturance:

The Personal Experience of Senior Women Living on Limited Incomes

Health promotion among the senior population is a timely and important area for community health nursing practice and research as the proportion of people over 65 continues to increase. Senior women constitute a group of seniors whose unique health issues and needs are often overlooked. When compared to senior men, senior women have an increased likelihood of living their remaining years in poverty. In Canada, 43.4% of unattached women age 65 and above live in poverty (National Council of Welfare, Spring 1997).

It is widely accepted that health and health promotion are inversely related to income, however, the personal experience of those living on lower incomes who are attempting to promote their own health has been relatively unexplored, particularly with regard to the senior population. Up to now, health promotion services provided by public health nurses have primarily been focused on young families to the exclusion of older individuals in our society. In addition, very few studies on health promotion have been conducted with a focus on senior women. Only two studies have been conducted on health promotion as described by senior women living on limited incomes (Butler, 1993; Sharpe & Mezoff, 1995); however, both studies used a sample of rural women, thus ignoring the urban perspective. There exists a need to gain a deeper understanding of health promotion from the perspective of urban senior women living on limited incomes who may be at increased risk of lower health promotion participation and poorer health status. Only then can health professionals, program

planners and policy developers begin to offer appropriate and effective services that have the potential to increase the quality of life and independence of this group of women.

The purpose of this study was to investigate the perceptions and experiences of health promotion as described by senior women living on limited incomes. Interviews with eleven urban women over the age of 60 were conducted in order to elicit how they defined health, their attitudes towards and experiences of health promotion as well as their health promotion service utilization. The relationship between low income and health promotion was also explored during the interviews. This paper will focus on the personal experience of health promotion as described by this group of women as well as the effects that living on a limited income has on their ability to promote their own health.

Literature Review

Health promotion has been defined as "...a diverse set of actions, focused on individuals and their environments, which increases control over, and ultimately improves, health or well being" (Rootman & Goodstadt, 1996, p. 4). Health promotion for seniors has numerous objectives which include the maintenance or improvement of functional status, increasing seniors' knowledge and practice of health behaviors, increasing quality of life for seniors as well as assisting them to discover and treat health problems early (Laffrey, Renwanz-Boyle, Slagle, Guthmiller & Carter, 1990). The majority of research in this field has been concerned with determining the factors associated with seniors' increased participation in health promotion programs

or engagement in health promotive behaviors. Psychological factors associated with increased participation in health promotion include perceived self-efficacy, high self esteem, an internal locus-of-control, health knowledge, health motivation and health responsibility (the latter three being subscales of a self care agency scale) (Barker Bausell, 1986; Hanner, M. E., 1987; Duffy, 1993; Rauckhorst, 1987; Cunningham, 1990). Behavioral factors include being a nonsmoker, having a wide social network, high functional status, having a supportive family and high community involvement (Elward, Wagner & Larson,1992; Watkins & Kligman, 1993; Wagner, Grothaus, Hecht & LaCroix, 1991; Rakowski, Julius, Hickey & Halter, 1987). Finally, some personal and social factors associated with increased senior participation in health promotion are high perceived health status as well as a high level of education and income (Wagner et. al., 1991).

Numerous studies have been conducted to evaluate the efficacy of health promotion programs with seniors. Positive behavioral effects of senior participation in these programs include decreased dietary fat, salt and alcohol intake, decreased smoking, weight loss and increased exercise (Fries, Tilton Fries, Parcell, & Harrington, 1992; Harper Howze, Smith & DiGilio, 1989; Grant Higgins, 1988). Positive health outcomes of these programs include increased life satisfaction, decreased stress, increased psychological well-being, increased cardiovascular health, increased joint flexibility and decreased blood pressure (Foster, 1992; Fries, et. al., 1992; Cowper, Morey, Bearon, Sullivan, DiPasquale, Crowley, Monger & Feussner, 1991; Grant Higgins, 1988; Ebrahim & Williams, 1992; Harper Howze, Smith & DiGilio, 1989).

Health promotion programming has also been found responsible for keeping frail seniors living at home (Hall, De-Beck, Johnson, Mackinnon & Gutman, 1992).

Health promotion programming for seniors appears to be rarely geared specifically towards senior women despite the fact that senior women's health experiences are quite unique. In addition to experiencing higher rates of hypertension and arthritis/rheumatism when compared to senior men (Statistics Canada, 1990), senior women may find themselves faced with diseases such as breast cancer and osteoarthritis. Unattached women over the age of 65 are also more likely to live below the poverty line in Canada than their male counterparts (National Council of Welfare, Spring 1997). In Canada, the 1995 poverty line had been estimated under Statistics Canada's Low Income Cut-offs to be $15,819/year for a person living independently in a city population 500,000+ (National Council of Welfare, Spring 1997). The Canadian Public Health Association (1997) discusses possible reasons for the above gender discrepancy: women's likelihood of living longer, widowhood which brings with it a decrease in supplemental and pension income as well as a lack of "... steady attachment to the labour force or access to job-related pensions" (p. 14) in earlier years.

The relationship between income level and health has been well documented over the years. Income level in adults has been found to be positively correlated with positive affect, fewer number of health problems, life satisfaction, a high level of physical functioning and fewer medical checkups (Brown, 1993; Moore, 1992; Foster, 1992; Guralnik & Kaplan, 1989; Maynard, 1991). Not surprisingly, in a study

addressing the health care and transportation of poor, frail elderly in Southern Florida (Rittner & Kirk, 1995), 77.5% of subjects rated their health as poor or very poor. Cairney & Arnold (1996) also showed that low income adequacy has a negative effect on selected health indicators of non-institutionalized Canadian elderly. Jagger, Spiers & Clarke (1993) were the only researchers whose results showed no relationship between low socio-economic status and lower functional status. The authors attribute this surprising result to the instruments used in measuring these concepts as well as the homogeneity of their sample.

With regard to health promotion, studies have found that low income levels are associated in adults with decreased physical activity, lack of dental checkups, decreased mammograms and pap smears, lower health responsibility, poorer nutritional intake, lower decreases in dietary fats and lower overall scores on health promoting lifestyle measures (Rakowski, 1993; Jensen, Counte & Glandon, 1992; Walker, Vokan, Sechrist & Pender, 1988; Norton & Wozny, 1984; Stone & Fletcher, 1986; Statistics Canada, 1995; Makuc, Freid & Kleinman, 1989; Hanner, 1987). Alternatively, Wister's (1996) data showed income to be a weak predictor of smoking and not an important predictor of activity level in Canadian seniors. One study was found whose results showed seniors with lower incomes scoring significantly higher on the Health Promoting Lifestyle Profile. The authors caution, however, that subjects in this study comprised a convenience sample who were somewhat more educated and had higher incomes than the U. S. average.

Seniors' perceptions of health have been investigated in a number of studies (Davis, Henderson, Boothe, Douglass, Faria, Kennedy, Kitchens & Weaver, 1992; Johnson, cited in Heine, 1992; Rosenbaum, 1991; Viverais-Dresler & Richardson, 1991; Ballard Ferguson, cited in Ballard Ferguson, 1995; VanMaanen, 1988; Thorne, Griffin & Adlersberg, 1986; Davis, 1992; Wondolowski & Davis, 1991; Butler, 1993; Ruffing-Rahal, 1989). Overall, seniors in these studies seem to equate health with independence or general well-being rather than with the absence of illness. Seniors' attitudes towards health promotion have also been explored. The importance of personal health practices in the lives of seniors was supported by Ferrini, Edelstein & Barrett-Connor (1994) with seniors' perceptions of internal vs. external locus of control of health having been investigated by other authors (Rauckhorst, 1987; Barker Bausell, 1986). Motivational incentives for partaking in health promotion programming have been explored (Connell, Davies, Rosenburg & Fisher, 1988; Pascucci, 1992; Duncan, 1993) and seniors' experience of engaging in health promotion have been described as well (Miller, 1991; Viverais-Dresler & Richardson, 1991; Davis et. al, 1992; Frenn, 1996; Ruffing-Rahal, 1989; Kolanowski & Gunter, 1985; Butler, 1993; Sharpe & Mezoff, 1995).

Our current knowledge related to health promotion and senior women living on limited incomes is insufficient for a number of reasons. First, studies on health promotion and seniors have been primarily quantitative, focusing on predictive factors of health promotive behaviors. As a result, predetermined research questions contrived by researchers, have up to now, controlled the majority of data that are presently

available on this topic. What has rarely been addressed is the personal perspective and experiences of seniors towards health promotion. Second, those qualitative studies which do focus on seniors' perspectives, have for the most part, focused on the perspectives of both senior women and men. As a result, the health promotion experience of aging senior men and women is assumed to be the same, when in fact, it may not be. Third, senior participants in most studies are often living at a 'middle-class income level'. This demonstrates a lack of attention towards the potential effects that living on a low income may have towards health and health promotion. The authors of two qualitative studies (Butler, 1993; Sharpe & Mezoff, 1995) have examined health promotion as described by lower income senior women; however, participants in both studies were American and living in a rural area, thus ignoring the unique experience of Canadian, urban senior women.

Methodology

A qualitative exploratory, descriptive study, using ethnographic methods was undertaken for the purposes of this research project. Field (1983) states that an "ethnography is a systematic attempt to discover the knowledge a group of people have, and are using, to organize behaviour. It involves first-hand study of a culture..." (p. 3). In nursing, the study of cultural groups is significant in that it provides a much needed personal perspective from which to guide future interventions and programs (Morse & Field, 1995). The culture described in this paper is that of senior women living on limited incomes who either reside in or access senior resources in an urban inner city area. Eight geographical areas were determined to be 'inner city' as defined

by the city's social planning council. The primary location for this study was a senior's inner city drop-in centre which serves a primarily low-income population. The centre is open to seniors over fifty five and provides two main services: a free meal program and recreational services. A nurse from the neighboring health centre visits weekly as does a footcare nurse. In an effort to develop a sense of the context in which health promotion occurred for a number of the participants, the researcher volunteered at the drop - in centre one hour per week over the course of the project. Field notes were taken following individual meetings with all the participants.

Participants

A total of nineteen senior women were interviewed; however, eight of these nineteen women indicated during the course of the interviews that they did not believe that they lived on a limited income. Thus, interviews with eleven women were analyzed for the purposes of this research study. Purposive sampling took place over a period of five months, during which time senior women attending the senior's drop-in centre , who met the selection criteria, were approached and asked if they would like to participate. Each woman was provided with a written information sheet as well as a verbal explanation of the study prior to being asked if they could be contacted later for an interview. In order to increase the heterogeneity of the sample, senior women who resided at an inner city senior's lodge were also approached in this fashion. As well, outreach workers associated with the drop-in centre referred clients who lived more socially isolated lives. Finally, a presentation was made to an inner city Senior's

Fitness/Wellness Group, facilitated by a public health nurse, in order to recruit additional women.

Participants were recruited who were female, age 60 or over, as well as living in the inner city and/or accessing senior services in the inner city. Although most studies of this nature define seniors as being over the age of 65, the age of 60 was chosen in order to increase the cultural and income level diversity of this sample. Participants were required to be able to comprehend and speak English, have an interest in taking part in the study and be able to express their perceptions and experiences as it relates to health promotion. In order to obtain a thorough and deep description of the experiences of health promotion by these women, the researcher sought out women from a wide variety of backgrounds (i.e., women varying in ethnicity, age, education, physical/mental health status and social support). Based on two related published ethnographies in this area (Miller, 1991; Rosenbaum, 1991), it was anticipated that the total number of required interviews would be approximately twenty to thirty. Sampling continued in this study until the amount of data obtained from senior women living on limited incomes was sufficient to adequately answer the research question at hand (Morse, 1991). In the end, all but two of the eleven women were interviewed twice, bringing the total number of interviews to twenty.

Data Collection

At the beginning of each interview, the researcher reviewed the information sheet with the participant and asked her to sign a consent form which was read out loud if she so requested. After signing the consent form, the semi-structured, taped

interview session began with the collection of biographical data and the question, "Do you think you are healthy?". Questions with regard to the participant's perceptions and experiences of health promotion, health promotion service utilization, as well as the effects that living on a limited income may have on health promotion followed. All questions were worded in such a way so as to ensure that senior women who may have had a low literacy level would be able to understand. The term health promotion, for example, was replaced with 'what one does or how they live their life in order to maintain or improve their health'. Fieldnotes were taken after each interview in order to record the environment where the interview took place, the participant's non-verbal expressions as well as any interruptions which occurred. Interviews ranged in length from half an hour to approximately one hour. Six of the interviews took place at the drop-in centre, eight in clients' homes and six occurred in an office at the inner city lodge. All interviews but one were tape-recorded and transcribed by a professional transcriptionist. Interview notes were taken by the researcher when during one interview, the tape-recording equipment was unavailable.

Ethical approval for the study was obtained from the participating educational institution and agencies. All participants were provided with a consent form outlining their participation level, how confidentiality and anonymity would be protected as well as the lack of benefits or risks involved with participation. A number of the women were referred to health professionals/agencies with their verbal consent when certain health problems/issues surfaced over the course of the study.

Data Analysis

The analysis of data was guided by four stages as described by Morse (1994): comprehending, synthesizing, theorizing and recontextualizing. During the comprehending stage, literature related to the research study was sought out and read. Transcripts were checked against the tape recordings as they came in to ensure accuracy. The researcher read through each interview transcript a number of times prior to beginning coding with the use of the qualitative software program NUD.IST (Non-numerical Unstructured Data Indexing, Searching and Theorizing). Coding was accomplished by sorting through and grouping words and sentences according to their meanings and relationships to one another (Miles & Hubberman, 1994), first on the transcript hard copy, then on computer. As expected, patterns began to form which later developed into categories and subcategories held together by common themes (Morse, 1994). Memo-taking during this time assisted with identifying gaps in the categories and patterns in the data.

Synthesizing involved analyzing the data more holistically (Morse, 1994). Typical and atypical cases were sought out in order to help identify the underlying phenomena being described. Examples from interviews were elicited to help illustrate the women's experience of health promotion (Morse, 1994) and data from the first stage of analysis was 'pulled together' and condensed, thereby providing an understanding of the phenomena on a much more conceptual level (Miles & Hubberman, 1994). During the third stage, theorizing, alternative models were compared against the forthcoming data in an attempt to explain differences between

studies. This allowed for norms, values and behaviors which emerged from the interviews with these women to be further interpreted (Morse, 1994). During the recontextualizing phase, comparisons between the model, 'Health Promotion as Self Nurturance' and other existing models were made in order to derive broad conclusions about how senior women living on limited incomes may experience health promotion.

Characteristics of Participants

A total of 11 women participated in this study. The age of participants ranged from 62 to 87 years with the average age being 73.5 years. Four of the women were widowed, five were separated or divorced, one was married and one was single. All but one had children, ranging in number from one child to eight. Cultural affiliations varied: one of the women was Aboriginal Canadian, four were of Eastern European descent and four were of European background. The cultural background of two participants is unknown. All participants believed that they lived on a limited or low income; however, a few stated that despite this status, they were 'able to get by'. The average monthly income for those who chose to report it (8/11 participants) was $794.77 with incomes ranging from as low as $461 per month to as high as $1116.00. Six out of eight reported incomes fell in the $800-$1100 range. Three of the participants did not know their monthly income or chose not to report it. Sources of income varied among the participants and included Canada pension, widow's allowance, old age security, social services, and the senior's benefit.

The education level of participants varied as well. One participant had received no formal education, five had gone as far as grades 6-10 and three of the women had

taken senior high school courses as well as completing a diploma course. One stated that she had completed high school in her home country and one of the participants did not know her highest level of education achieved. None of the participants were currently employed although a few were actively involved in volunteer work. The majority of participants had worked in low paying jobs in the past: restaurant work, sales, factory work, farming and baby-sitting. Two of the participants had worked in health care in the past, two reported being on welfare at some point in their lives and one described her past occupation as 'housewife'. The present living situation of participants was as follows: four rented apartments, one rented a house, three were homeowners and three resided in a senior's lodge. Seven of the eleven women were living in the inner city.

All but two of these participants considered themselves to be healthy despite contending with a wide range of health problems. Illnesses experienced at the time of the interviews included diabetes, hypertension, chronic pain from previous fractures, arthritis, and asthma. A number of the participants were also living with cancer, organ failure, and mental illness.

Findings

Over the course of data analysis, it became apparent to the researcher that the eleven women described their personal experience with health promotion as a form of self nurturance. This phenomena can be divided into four major elements based on the wide variety of ways these women chose to maintain or improve their health: nurturing the physical self, nurturing the intellectual self, nurturing the social self and nurturing

the emotional/spiritual self (Figure 1). The women also described how living on a low income affected their own abilities to engage in self nurturance.

Nurturing the Physical Self

Nurturing of one's physical self was described by all of the women during the course of the interviews, with exercise and nutrition being the areas discussed most frequently. Other methods included efforts to prevent disease, relaxation and accident prevention. All but one of the women discussed the use of exercise in maintaining or improving their health, with walking being mentioned by nine of the participants:

> ... where I live I have to walk two or three blocks in the morning and I also have to walk through the mall and in the evening I have to do that same walking thing. So I have about six blocks a day which is, you know, not bad...

Other forms of exercise included dancing, swimming, bowling and stretching. One of the women explained the benefits of attending a weekly aerobics class at the local community centre:

> ... when I go there I feel like a ... sack of potatoes and when I go home I feel very energetic.

Practicing good nutrition was another important way these women nurtured their selves. Many of the women discussed the importance of consuming food considered to be healthy:

> I am not a vegetarian but I think you get more good for your body out of your vegetables and fruits, your citric fruits and citrus fruits ... a good variety of vegetables so you get your vitamins and minerals.

Another participant expressed the importance of fluid intake:

> ... drink plenty of water for one thing ... to keep your system going and make sure you get at least three, eight ounce glasses of milk a day.

The avoidance of foods that contributed to disease was also discussed by a number of the participants. Five of the women discussed the need to avoid fat/cholesterol in their diets. One woman discussed the diuretic effect that drinking coffee had on her, another avoided spicy food on account of suffering from ulcers and a third woman mentioned that she avoided sweets due to diabetes. Weight management was mentioned by two of the women.

Disease prevention was another method used by this group of women to nurture their physical self. Maintaining cleanliness was deemed to be important as indicated by statements such as, 'cleanliness is next to godliness'. Some of the women were actively involved in monitoring their own blood tests, whereas others felt that undergoing medical treatments to fight disease, compliance with their doctor and regular voiding were critical to maintaining their health. Taking medications was discussed by seven of the women:

> I had a nervous breakdown when I was close to 18 and they diagnosed me as schizophrenic, so I have had that all my life and I have been on tranquilizers all my life, ever since I was 18 - but I have cut down to 1 milligram a night. I began with 10 milligrams a night and I have cut it down now.

This same woman discussed her interest in herbal medicines, in particular, Aboriginal home remedies, stating "they [Aboriginal Canadians] sure were wise in using nature's things".

Two of the women discussed undergoing screening tests in an effort to detect any possible disease at the earliest stage:

> ... I asked for a complete checkup, I told them I had been living in the city now for about _____ years ... and I said, 'I have been in several places that were not exactly hygienic'. And mice and bugs and stuff, you know, and I said, 'I'd like to see if I've picked anything up.' So I think they took about ten pounds of

> blood one at a time, you know, over a period, took about three months, tested me for everything, TB, VD, AIDS, the whole bit. And nothing.

Disease prevention also meant the avoidance of disease-inducing behaviors for many of these women. Three of the women had had problems with drinking alcohol in the past and as a result, took steps to ensure that they did not relapse during their later years. Others mentioned the importance of not smoking while two of the women attempted to avoid environments where smoke filled the air. A few of the women believed that taking medications was harmful for their bodies as evidenced by the following statement:

> ... the nurse or the doctor will come and tell you right there when they are giving you something, 'this may have some side effects'. Well, watch the side effects ... because when they say that they are going to injure your health one way while they are helping you another way. So my attitude is don't take them at all, don't touch them, keep away from all that. If you are in desperate pain you have to, you know, painkillers sort of. But as [far as] taking these things to make you better - are they making you better or are they making you worse?

A number of the women in this study discussed the importance of accident prevention in nurturing their physical self. Utilizing functional aids such as walkers, canes, bath rails or other equipment was found to be important for some. Three of the women mentioned that they avoided going outdoors in the winter in case they slipped and fell on the icy streets.

Finally, some of these women nurtured their physical self by taking time to relax. One of the women found that listening to music was 'soothing' while another participant stated,

> You go out when you can go out, if you feel like you want to rest, lock the door and pull the quilt over your head! (laughs)

Nurturing the Intellectual Self

In describing their personal experience of health promotion, many of these women discussed aspects of their lives which contributed to intellectual growth in their later years. Nurturing the intellectual self was described in a number of ways: staying active, maintaining interests, accessing media, accessing health promotion services as well as engaging in interpersonal and intrapersonal interaction.

Many of the women strongly emphasized the importance of staying active through various kinds of work - housework, volunteer work or other activities that provided them with a sense of purpose and productivity. One woman expressed the source of these values:

> My mother was always the kind of person who always said, 'If you don't feel well you work it off.' So I was brought up that way, that you just don't lie down and sit.

Aside from staying active, many of these women discussed the importance that maintaining interests had in promoting their health.

> ...without interest in people around you or in doing something, I figure you've got nothing to urge you on, you know. You just sit there and vegetate.

Many talked about reading, cooking and handiwork as personal interests they took part in. Two of the women discussed their love for gardening in the summer while another three discussed taking classes through community centres. One woman had taken a computer course offered for seniors while another had attended a drop-in nutrition class in the inner city. Writing letters and playing games were other interests discussed by some of the participants. Travel or taking holidays was mentioned by only

two of the participants which is not surprising due to the participant's low income status.

Accessing the media was a third form of nurturing one's intellectual self. Three of the women mentioned that they had read articles about health issues, either in health magazines, the newspaper or books. Four women discussed their experiences of obtaining health information through radio and television. One of these women commented that shows such as 'Alive' or 'How to Grow Old' represented an increasing interest in the health of seniors compared to forty years ago. Another woman's comments reinforced the power that popular television programming has in changing health behavior during this day and age:

> Like I heard something on Oprah Winphrey the other day ... this woman was on her program and she says she writes down five positive, good things that happen to her every day and it changes your whole day. I've started doing that.

A fourth method these women used in nurturing their intellectual self involved accessing the services of professionals in the community. When asked what professionals helped them to maintain or improve their health, all of the participants discussed their doctor to differing degrees. Many spoke highly of the role that their doctors played in helping to diagnose and fight disease. Six of the women mentioned that their doctors had provided them with counseling and/or health education in the past. Two of the women expressed their frustration at some of the doctors' inability to help them with their illnesses. Nurses, who were mentioned by nine of the eleven women over the course of the interviews, also played a part in assisting senior women to promote their own health. A wide variety of nurses were reported: from homecare

nurses, public health nurses, footcare nurses, hospital nurses, day program nurses and clinic/community health nurses. Similar to the role described of doctors with the exception of diagnosis, most participants spoke of the nurse's role in terms of helping to treat or prevent disease (i.e., blood pressure monitoring, administration of medications, etc.). One participant had worked collaboratively with a neighborhood public health nurse on community development initiatives for seniors and viewed the role of the community health nurse from a much broader perspective. She described their work together this way:

> Well, next month ____ is going to come and bring us all the changes in the seniors'benefits and through the summer we arranged a bus tour for the seniors in this area. We've had people speak on arthritis and people speak on the heart and different things like that, ...

Other health professionals described by these participants as being involved in health promotion included pharmacists, a physiotherapist, a dental hygienist as well as health researchers. Two of the women were interested in the work of herbalists/ naturopaths as well, though one of them stated she could not afford to see one. Women in this study also commented on the help they had received from other professionals including a lawyer, banker and drop-in centre/lodge staff in stimulating their mind during discussions. One woman discussed the assistance provided by a social worker in helping to find additional sources of income:

> So now the social worker at the _____ (hospital) said she is going to write me out a form and maybe even give me a cheque and then make it out so I get one every month right here. She said she is going to ask [for] about $50 or $60 so that way I can get clothes at least, I haven't got hardly any clothes.

Finally, the two remaining ways these women nurtured their intellectual self was through interpersonal interaction and intrapersonal interaction. Family and friends were often cited as sources of information and support with regard to health promotion. Whether it was modeling other people's behavior or exchanging advice, interaction with others was often seen as being quite useful:

> Well, my oldest son from _____ phones me up pretty well every week and we have a good long discussion and he says, 'How are you, Mom?' and, "Is there any improvement or is there any things that are stressing you?' and "How is the rest of the family?' and everything like that and we talk a long time about health matters. Yeah, ... it gives me encouragement, you know.

Intrapersonal interaction involved the women making health promotive decisions based on their personal experiences, including past work experience. One of the women stated that she had learned how to promote her health over the years by 'trial and error' while two cited knowledge that had been fostered in their professional lives early on. The art of self-reflection was also seen as a form of intrapersonal interaction that promoted health. When contemplating suicide at a time in her life, one woman commented, "If I did that what would my children think?"

Nurturing the Social Self

There was an overwhelming sense among all participants that engaging in activities which nurtured their relationships with others and their own place in their community was an important part of maintaining or improving one's health. The women described three ways of nurturing the social self: social connectedness, neighborhood living and political action.

Social connectedness with others, whether it be social acquaintances, friends, or family was viewed as being a significant component of health promotion. One woman summarized her family's support in the following way:

> ... that working daughter, comes to see me, she phones me and says, 'Mom, do you need anything? I'll bring [it to] you on the way'. So they bring me whatever I want. But I've got ... good children and good grandchildren and even great-grandchildren. So I think that's what makes me happy and gives me health. Because so if you are happy you feel healthy, ...

This same woman spent some time during her interview discussing the importance that having a pet was for her. Her cat provided daily companionship, helping to soften the loss of her husband who had passed away.

Many of these women maintained social connectedness through activities in their communities. Inner city social support agencies, recreational services and senior's associations provided assistance to a number of the women. One woman frequented a number of places such as the Salvation Army, clothing bank and food bank in an attempt to collect what she called, "free doos". Another two women explained they were grateful for receiving free meals at a drop-in centre they attended, however, the meals seemed secondary to the social benefits of attending the centre. Drop-in centres and other neighborhood senior agencies provided recreational services, however a number of the women disliked the fact that group craft activities were offered infrequently. Despite this, many were grateful for the daily living support provided in the form of transportation services and personal assistance with groceries or medical appointments:

> ... they take people shopping, too, on Thursdays, and that really helps. Get the seniors out, they don't have to pay for a taxi. They (seniors) are afraid to go

> out, they might fall down or ... won't be able to carry the groceries, somebody is there to help them.

Another woman expressed her feelings about a recreational service staff member this way:

> ... she has a way of talking and it makes you [feel]... as if you are wanted, ...

One woman talked about the income tax services she received from the Society for the Retired and Semi-Retired and another two planned on contacting this same agency in the future. On the whole, this group of women appeared to be fairly well connected to senior support services in the community as well as to the family and friends in their lives.

A second effort employed by some of these women in nurturing their social self was working to improve their immediate living situation in their own neighborhoods. One way this was accomplished was through appropriate housing choices. Proximity of services and family were important to some of these women as was personal comfort. Two of the women commented on the importance of affordable housing and one spoke about the importance of living in a clean home. Ensuring transportation was another very important part of neighborhood living for these women. Only one of the women in this study stated that she drove her own car at this time with the remainder appearing to rely on the city transit system and/or friends or family for assistance. Some of the women utilized transportation provided by inner city seniors' agencies.

A number of these women spoke of taking safety measures in order to live more comfortably within their neighborhoods. Most of these women lived in the inner city and were keenly aware of the high crime rate within their midst. Three recounted

episodes of violent crime that had occurred within their neighborhood and one commented that she lived close to an area of high prostitution. Avoiding the streets after dark and having a keen awareness of one's surroundings even when at home were mentioned by some. One woman made sure to avoid places where teenagers and 'dope problems' occurred. Another woman had her home equipped with an alarm system, two front doors and a deadbolt in order to ward of intruders.

The third form of nurturing the social self described by many of these women was political action. Although participants were not asked directly about politics during the interviews, with a provincial election approaching at the time, six of the women freely voiced their concerns about the current state of the health care system in the province. One concern expressed by a few of the participants was current cutbacks to services such as homemaking assistance to seniors as well as new fees for eyeglasses and cataract surgery. One woman expressed her anger at the premier's debt-reducing actions, stating, "... he shouldn't get rid of the debt through the seniors, he should get it some other way, surely!". The same woman expressed her fear that she was starting to see the early signs of a two-tiered health care system:

> ... eventually I was afraid that they would take the whole health care away because ... they seem to be running in that way, you know. Destroying the beautiful Canada, health care in Canada, because there is no where in the world [where] you can get things like you can in Canada. I mean, it is just fabulous, it is out of this world, it is a dream place, now why take that dream away?

Methods used by some of these women to express these frustrations included talking with others about the current health care situation, letter writing to politicians, and voting on election day. One woman phoned her MP to complain and after no action,

called a local broadcaster to voice her concerns. Another participant suggested that perhaps nurses could become involved in helping seniors to become more politically active on issues that were important to them and the entire community.

Nurturing the Emotional/Spiritual Self

The final theme to emerge from interviews with this group of senior women was their tendency to find ways of nurturing their emotional/spiritual self. Many of the women reflected on ways of living that allowed them a greater understanding of their inner selves and a certain level of peace. Nurturing the emotional/spiritual self was expressed in eight primary ways: giving, thinking of the future, keeping positive, maintaining personal identity, religious practice, resiliency, assertiveness, and acceptance.

The act of giving to others was described by all but one of the women in this study. Giving to others could be expressed in a number of ways: giving time, gifts, information to others or love. As indicated earlier, a number of these women spent time volunteering their services. Helping others provided many with 'a good feeling'. One woman felt that volunteering allowed her to go home and 'rest easy' at the end of the day while another felt 'wanted' after donating her time. When asked how her involvement as a peer counselor in Alcoholics Anonymous (AA) helps her, one woman responded:

> Because it's a spiritual program and we are talking spirituality with friends and if somebody calls in and we make what we call a 12 step call, we are trying to ... talk to them about what life can be instead of staying where they're at so automatically I am helped in seeing the change in other people.

Although all of these women believed they lived on a limited income, many enjoyed giving gifts to other people. Two of the women talked about occasionally giving any 'left-over' money to family members while another enjoyed knitting quilts for her grandchildren. One woman collected old clothes from the Salvation Army and washed and repaired them before passing them on to her children and friends. If the clothes could not be used by the people she knew, she would return them to the Salvation Army in their upgraded condition. Giving was also expressed by some women in the form of providing information to other people as well as giving love. One participant expressed a form of giving love in the following way:

> ... I believe once you've done something good from your heart that it comes back. You know, and you don't have to always do it with money either, ... you can do it with little acts of kindness and little deeds or little words to people that are down, you know, kind of build them up and say, 'It's not that bad, maybe tomorrow it will be another day, ... '

Thinking of the future was a second method utilized by many to nurture their emotional/ spiritual self. One way of achieving this was by maintaining a sense of hope in good times and in bad. Three women discussed the importance of having hope in their lives. One woman's personal struggle with cancer was strengthened by having seen others fight and survive this disease in the past. Another woman stated that hope allowed her to continue to survive after the loss of her husband. Still another expressed her feelings this way:

> ... like most people that are trying to die, I am trying to live (laughs). A lot of people try to die, I think that's awful to get that way - to feel that you want to die - because life is sweet and it's good and if you can look at the bad parts and hope, you have to have hope. Hope that life will always be better rather than worse.

Aside from having hope, many of these women discussed their personal goals in thinking about the future.

> Well, if you don't try for something, if you don't have some goal or some idea ... that you want to go on living, first thing you know you slide down the tube. You know, you lose all interest in anything...

Stated goals included such things as living as long as one's parents or moving to a different location. One woman wanted to take an autobody repair course, another wanted to visit the Holy Land while a third woman commented to the researcher, "You know, ____, the last thing I want in my life before I die is to have an old time waltz". This same woman who happened to be an insulin dependent diabetic for many years, described an interaction with her doctor in which she noticed a poster on his office wall that stated, 'Reach your goal!'. When she commented on this poster, he asked her, "And what is your goal?". She replied, "When I don't have to take these pills and needles". As a result of the ensuing discussion, the doctor decided to take her off insulin and prescribe oral medication for her diabetes instead.

A third method that was used to nurture one's emotional/spiritual self involved working to keep a positive attitude. One of the participants stated:

> ... I think our mind controls so much of how we are and where we are and I think that our attitude makes a big difference and I think as long as my attitude is right I am ok.

One way of staying positive was to make an active attempt to divert negative thoughts or actively think positive thoughts. The woman above mentioned how she used to place positive messages beside her at work during the day and would occasionally read them, stating, "... if my mind would wander off in a tangent, I didn't want it staying

there so I would have to consciously bring it back". Although she no longer feels the need to do this, she continues to read 'positive literature' and her bible in the mornings.

Four of the women discussed the importance of being selective of the friends or acquaintances they spent time with. This meant talking and visiting with people who were 'positive' and walking away from those who were not, in order to protect themselves. For one woman this meant deciding not to dance with a man who had been drinking; for another it meant choosing not to visit her daughter who frequently had untrustworthy friends over. Finally, two of the women described expressing thankfulness to others, one being to God, the other to friends that had helped her with financial problems. Being able to express gratitude was for these two women, one way to reflect on the positive aspects of one's life.

A fourth method used to nurture the emotional/spiritual self was through the maintenance of personal identity. None of the women stated this as such, however, over the course of the interviews, a number of the women spoke repeatedly of their past professional and personal accomplishments with a great sense of pride. One woman in particular mentioned that although 79, she still paid for her professional licenses every year, stating, "It will never leave you, you know, 'cause once you do it, you do it". Another woman frequently mentioned her love for farming and the outdoors. Still another found a great deal of personal pride in having raised two sons on welfare by herself: "The way I raised the boys, ... I held them in my hands, cried with them, but I held them good". Religious practice was considered to be an important way of promoting health for four of the women. Personal faith in a God was

expressed by one woman this way: " Well, when I believe that I get my strength from God then I believe I can do whatever is right there for me to do". This same individual discussed how she drew strength from reading her bible regularly. One woman attended church meetings sometimes twice a week, stating she felt "so good after". Three of the women discussed the significance of personal prayer, how it enabled them to communicate their feelings with their God and in doing so, helped them day to day.

Resiliency is presented here as the sixth method used to nurture the emotional/ spiritual self. However, this concept was one of the first to emerge from the data. It became quickly apparent that many of these women had suffered numerous hardships throughout their lives from failed marriages, to life-threatening illnesses, death of spouses and children, war time atrocities and struggles involved with settling in a new country. Despite all of this, there was an overwhelming sense that life would go on for these women and that they had somehow developed a way to protect themselves from the pain in their lives. Two strands of resiliency emerged from the interviews: coping and never giving up. Many coping mechanisms used by these women have already been described: staying active, accessing health promotion services, as well as interpersonal and intrapersonal interaction. One woman described living with arthritis in her right hand which caused it to swell, thereby limiting its functional capabilities. She felt it was important to try to make the best of one's situation, and stated: "... I had to learn to eat with the left hand but I still kept on going".

The second strand of resiliency was expressed as 'Never Giving Up'. Four of the women discussed the importance of this, in particular one of the participants who

was being treated for cancer. Despite the seriousness of her illness, she stated very strongly that she was a healthy person. When asked how a person could be healthy while having cancer, she replied, "If you catch it in time and don't give in, whatever you do don't give in, because you can fight it. You know what I mean?". The same woman stated during the interview, "... if you look after yourself, you know, you've got a fighting battle there, you know, a WINNING battle I should say".

Closely connected to the concept of resiliency is practicing assertiveness. The woman above displayed this characteristic in many of her statements as did three of the other participants. Assertiveness proved to be an important element in empowering some of the women to make decisions and take action to maintain or improve their health. One woman described assertiveness as having a 'bad temper' which had always helped her throughout life. She recounted giving advice to a friend on this topic after recovering herself from a debilitating accident:

> He says, ... 'How the hell do you do it?', and I just say, 'You just have to make up your mind that you are going to do it.' I mean, it is amazing what you can do once you make your mind up. It is, you know. I could have sat in that wheelchair for the rest of my life. But I got so damned ... mad at the thing I decided I was going to get up and walk. I mean, it might hurt you a bit at first but it's a lot better than vegetating and you've got to start somewhere.

The last form of nurturing one's emotional/ spiritual self was expressed by some of the participants as being able to accept one's situation when the time was right. Despite extensive talk of "never giving up", the woman described earlier who was living with cancer also referred to the importance of acceptance when she stated, "When my day comes, I'm ready". Acceptance for her also meant refusing the offer to go to the U.S. for a bone marrow transplant. She felt that she was too old for this

procedure and wanted those who were younger to have the opportunity over herself. The importance of acceptance was also stated eloquently by a woman who recited during the interview the following passage used in AA:

> God grant me the serenity to accept the things I cannot change, courage to change the things I can and wisdom to know the difference.

Living on a Limited Income and Health Promotion

The women in this study spoke freely about the experience of living on a limited income during their senior years and how it related to health promotion. Many of the participants spoke about the financial expenses they incurred during this part of their lives. The cost of medications was described by a few women as was medical supplies. Expenses for eyeglasses and a walker were also discussed. The women who were homeowners all talked about expenses tied to owning a home to differing degrees. These expenses included utilities, repairs, insurance and land taxes. One of these women who was considering selling her home and moving into an apartment , stated her situation "was getting harder and harder now". Another had been considering not paying for her provincial health care card which cost her approximately $102 every three months.

Living on a limited income was seen to have some negative effect on the health promotive behavior of most of this group. A number of these women were limited in what personal supplies they could purchase. Four of the women mentioned not being able to afford certain types of food that they wished to purchase and which they knew was healthy for them. These women were forced to make certain food choices based on their limited income, however, a note of desperation regarding an outright lack of

food or proper nutrition was never detected among any of the participants during the interviews. Another woman stated that she needed to purchase deodorant, baby powder and air freshener but at the time, she only had $7 in her possession. Three women commented on their inability to afford new clothes.

> Because I can't afford to be buying clothes, I don't get that much to live on. So what I have, has to do...

The ability to socialize was also affected by lack of income. One woman reflected upon her inability to visit relatives outside of the city due to the high bus fares. This same woman commented on the fact that living on a low income affected her ability to socialize by telephone:

> ... I even cut down on my phone calls, I only made two long distance calls since August. The telephone bill is $18 something a month so I can't afford it.

Recreational opportunities were seen as being affected by living on a limited income by three of the women. One stated that she would travel more if she lived on a higher income while another would have liked to join a club and attend more hockey games during her senior years:

> Yeah, even hockey games are getting to be too expensive now, you pay about ... well, for a half decent seat that you can see anything from, you go up 60 bucks for a single person and ... by the time I pay my rent and everything I have about $30 left. To get me through the month I, you know, you can't.

Another woman recounted angrily how she had been attending group yoga classes at a local gymnasium for ten years free of charge. When the organization insisted she start paying a fee to attend, she refused to return to them and today completes her yoga routine at home by herself.

Lack of income affected some participants' ability 'to give' to those they cared about most. Three of the women in this study recalled during interviews how they had been unable to provide services for their children on account of living on a limited income. Two of the three women commented on not being able to pay for post-secondary education for their children in past years. The third woman wanted to help her son find his natural father, however, she was unable to meet the high expenses required by a professional search organization.

Access to health promotion activities had the potential to be affected indirectly through lack of money for transportation. One of the women who lived at a lodge was grateful for the ride assistance they offered her, stating:

> By the time I have paid for a taxi I wouldn't have anything left for groceries, if you know what I mean, and I think that's limited.

Two other women echoed the sentiments of not being able to always afford a taxi.

Finally, a number of the women in this study discussed how living on a low income affected certain health care costs. One woman, driven by a fear of having to pay for cataract surgery herself, had written a letter to the premier voicing her concerns of the possibility of a two-tiered medical system. An exception to this was another woman who expressed that she didn't mind paying the $150 that was required for cataract surgery at a private clinic because it meant she may never have to wear eyeglasses again. The high cost of eyeglasses was expressed by another participant as being a concern over the course of the interviews.

Two of the women mentioned that they would have liked to make purchases at local health food stores but found them to be too expensive. Another woman avoided

purchasing 'high cholesterol pills' due to their being too costly. This same woman had been forced to make other health care choices as a result of living on a limited income:

> ... there have been times when I needed dental work done and had to go without it because I couldn't pay. They wanted to do a root canal on me ... just a little ways from here. [I said,], 'I can't afford it and I don't want it done,' and they said, 'Well, if your infection goes away we won't have to do it.' And low and behold it went away so I didn't have to do it, cause otherwise, ...

Many of these women described coping measures that they utilized to help offset the effects of living on a limited income. Spending one's money wisely was considered to be critical. One woman stated, "... you have to shop carefully, you don't just go throwing your money around.". A number of women commented on the importance of not wasting their money on cigarettes and alcohol, as did some in their midst. Two frequented used clothing stores and another woman decided to have the water turned off to her house as she was convinced that the city was charging her too much compared to her neighbor. As a result, this woman was forced to bathe at friend's homes or the neighborhood swimming pool in order to keep clean until the matter was resolved.

Budgeting was a second method described by five of the women in coping with their low incomes: "... you have to write it down and keep track of where you are at, sort of thing, even though it is only a little bit...". Living in low rent housing was mentioned by only two of the women, although more of the women likely lived in similar situations. One of the women stressed the importance of not wasting what one has:

> ... you've got to cook a pot of soup and make sure that you eat it today and save it yet for supper ... don't throw it away because you couldn't cook a little bit.

Two women expressed being grateful for governmental assistance that allowed them to be able to pay for their expensive medications and medical supplies. Acceptance of one's financial status was the final way to cope with living on a limited income. One woman who had lived most of her adult life on welfare had this to say about living on a limited income:

> You can't keep with the Jones' when you are in a very low income. Don't even think you could make it, just keep your clothes washed, clean and then put another button if it is missing. That's about ... [all] ... you can do.

In conclusion, living on a low income did appear to affect some of the health promotive behaviors these women had described earlier in the study: affordability of personal supplies, social opportunities, recreation as well as some health care expenditures. Income also appeared to influence a factors indirectly related to health promotion: transportation. Three of the women in this study, however, stressed the importance that personal choice plays in health promotion. All compared themselves to individuals in the community who had chosen to spend their money on alcohol or smoking as opposed to making more healthy choices. One woman went as far as saying that having too much money can be detrimental:

> If they get the money they like the chocolates or the bottle of beer or something like that which they know darned well they shouldn't have but if they got the money they'll go and get it. But if you have to be really careful of your money it makes you smarten up a bit more.

Questions pertaining to the relationship between income and health were not asked of the women during the interviews. However, three of the eleven women explored this themselves during the discussions. These three women wanted the researcher to know

that their income did not have an effect on their health status. In the words of one woman, "Money won't buy health or happiness. You try to make the best [with] what you got".

Discussion

The overall impression garnered from the discussions with this group of women was that, 1) this group of senior women used a wide range of 'ways of living' in an effort to promote their health, 2) living on a limited income directly and indirectly affected most participant's personal experiences of health promotion and 3) a number of the women did not believe there was a direct relationship between health status and income. The experience of engaging in health promotion as described by this group of senior women living on limited incomes reflects their ability to nurture four different elements of the self: the physical self, the intellectual self, the social self and the emotional/spiritual self. The relationship between these four primary themes is shown in Figure 1, which depicts an interconnectedness of the four elements that contributes to an overall nurturing of the self. In analyzing these women's experiences of health promotion, the concept of nurturance appeared to fit well with the lives they are living. It is important to distinguish the concept of 'self-nurturance' from the term 'self-care', which has been described as "... the decisions taken and the practices adopted by an individual specifically for the preservation of his or her health" (Epp, 1986, p. 7) and as, actions taken in response to physical symptoms or illness (Haug, Wykle & Namazi, 1989; Dill, Brown, Ciambrone & Rakowski, 1995;). *The Concise Oxford Dictionary of Current English* (Fowler, Mesurier & McIntosh, 1949) defines the word 'nurture' as

"fostering care" or "nourishment" (p. 778). Furthermore, the word nurturance is often equated with the idea of 'feeding something, which in turn, allows it to grow'. Utilization of the concept 'nurturance', therefore broadens the scope of self-care which appears to have a limited focus on actions or behaviors.

The first major finding of this study was that the women participants utilized a wide variety of "ways of living" which at times, overlapped each other. The inter-connectedness of the four elements of the model (physical, intellectual, social and emotional/spiritual) is in some cases, supported by statements made by participants themselves. That is, although the health promotive behaviors have been subdivided into categories for the purpose of describing the model, many of the women acknowledged that certain 'ways of living' brought forth benefits that could belong to more than one sphere. Such was the case with a woman who wanted to take up swimming in order to lose weight, meet new people as well as further develop this personal interest she had maintained for many years. Another woman spoke earlier of the social, emotional and spiritual health benefits involved with her volunteer work with Alcoholics Anonymous. Interestingly, the interconnectedness of health promotion elements has been described by a number of other authors as well (Hartweg, 1993; Frenn, 1996).

The four elements of *Health Promotion as Self Nurturance* coincide with much of today's literature which defines health as varying combinations of physical, mental, spiritual and social well-being (Milsum, 1991; Ruffing-Rahal, 1989; Rootman & Goodstadt, 1996; Hamilton & Bhatti, 1996). Green & Raeburn (1988) comment on

the fact that the WHO's definition of health is positive and holistic as opposed to focusing on health as the absence of illness. Robertson & Minkler (1994) emphasize an additional aspect of the WHO's definition: that health is a resource for living rather than an endpoint which humans continually strive for. Other contemporary conceptualizations of health view it as a process-oriented phenomenon that lies on a separate continuum from illness, thereby allowing individuals who are perhaps physically ill, to also be healthy (Allen, cited in Kravitz & Frey, 1989; Gottlieb & Rowat, 1987). The developers of the McGill Model of Nursing have stated that two central processes of health are coping with life events and developing towards life goals (Allen, 1983; Gottlieb & Rowat, 1987). These definitions of health are in accordance with how the women in this study discussed health promotion. Health promotion was rarely mentioned as one or two separate actions or behaviors, rather, it was seen as a multitude of 'ways of living'. The fact that most of the women perceived themselves as healthy despite living with a wide variety of illnesses supports the definition of health as described above. Their own definitions of health, though not reported in detail at this time, reflect the dynamic nature of this concept: independence, happiness, activity and sense of wellness. These definitions as well as the women's descriptions of health promotion left the researcher with the sense that participants in this study were continually growing and changing throughout their senior years.

Finally, the extent to which these women practiced health promotion from a very broad - based approach can be seen when examining *The Ottawa Charter for Health Promotion* (World Health Organization, Health & Welfare Canada & Canadian

Public Health Association, 1986). This document describes health promotion action as comprising five areas: 1) Build Healthy Public Policy, 2) Create Supportive Environments, 3) Strengthen Community Action, 4) Develop Personal Skills, and 5) Reorient Health Services. Although it might be assumed that the health promotive work of the women in this study would fall solely under the development of personal skills, some of the comments pertaining to social connectedness, volunteer work in their communities and political action provide evidence that low income senior women can and do promote health on a much wider scale.

The experiences of health promotion as described by this group of low income women appears to closely resemble that described in related qualitative studies. Interestingly, this appears to hold true despite the middle income status of participants in five similar studies. In the first study conducted by Miller (1991), two major factors were found to be contributing to the health of middle- high income senior men and women: the activities they engaged in as well as maintaining relationships. Further elements included: altruism, resiliency, ambition, hardiness, global concerns and meta-aging/self-actualization. Viverais - Dresler and Richardson (1991) utilized quantitative and qualitative methods in interviewing twenty-eight senior men and women, 60% of whose income was $20,100/year and over. Health promotion practices discussed by this group included staying active through exercise and volunteering, nutrition, maintaining relationships with others and coping. These participants also used religion as a source of support.

A third study by Kolanowski & Gunter (1985) which focused on the health promotion experience of middle income senior women elicited themes similar to those described in the *Health Promotion as Self Nurturance* model. Two additional studies report on health promotion as described by seniors whose income level is unknown. Ruffing-Rahal (1989) describes three core categories in the 'well-being experiences' of twenty-seven elderly men and women: activity, affirmation and synthesis. Participants were purposely recruited here who seemed to typify 'well-being' and although incomes were not reported, many were well educated. Finally, Rosenbaum (1991) explored the meaning of health and health practices of senior Greek-Canadian widows. The health practices described by these participants were by far the most narrow in scope and were limited to exercising, eating nutritious meals and seeking fresh air. Participants also described a number of Greek folk remedies used in treating illnesses.

The second major finding of the present study was that low income was discussed by many of the women as directly and indirectly affecting their experience of health promotion. It is important to note here that although income was discussed as a condition influencing health promotion by the women in this study, this and other factors were purposely left out of the *'Health Promotion as Self Nurturance'* model (Figure 1) in order to maintain the focus on what these women described as ways in which they promoted their own health. Of additional interest was the fact that three of the women in this study expressed the belief that their income had no effect on their health status. This will be discussed in more detail soon, however, it is first useful to

review those studies in which the experience of health promotion by low income seniors has also been described.

In the first study conducted by Davis et. al (1992), the experiences of health promotion was described by rural male and female seniors who had an average income that was low but still above the poverty line. Subjects described having a nutritious diet, exercising and taking required medications as behaviors which maintained or improved their health. The participants also discussed the importance of 'keeping busy' and staying optimistic. These authors unfortunately refrained from any in-depth discussion of the relationships between the participant's income and their health promotive behaviors.

Frenn (1996) utilized grounded theory methodology to develop a theory of 'Older adult's experience of health promotion'. She conducted 31 semi-structured interviews with low-middle income male and female participants, engaged in participant-observation techniques and distributed a tool to participants which measured personal motivation for health. In the end, this author came up with a process entitled, 'Going about health' whose "major patterns included maintaining relationships, attending to health behaviors and staying active" (p. 67). Intellectual pursuits were described as one of the influencing factors related to health promotion and statements related to nurturing of the spiritual self appeared to be limited. The author acknowledges that "differences in the patterns of Going about Health were not apparent by respondents' incomes. Rather, dealing with life challenges and low income

was described as an additional burden that had to be addressed before health promotion could be pursued" (Frenn, 1996, p.70).

Two studies have investigated health promotion as described by low income, rural women. First, Sharpe & Mezoff (1995) interviewed twenty participants who only discussed their beliefs and practices surrounding diet and health. Butler (1993) on the other hand, elicited a wider variety of themes from eight older, rural women: "giving, staying busy, primacy of family, resiliency and adaptation with acceptance" (p. 56). Interestingly, these latter themes correspond with elements seen in nurturance of the intellectual, social and emotional/spiritual self, with themes corresponding to nurturance of the physical self rarely mentioned. Butler (1993) acknowledges that the participant's income had an affect on the choices they made in their lives, "however, the women did not complain about poverty, ill health, or other hardships in their lives, but rather faced their challenges with resiliency" (p. 63). One of the women in Butler's (1993) study even acknowledged the sentiments expressed by three of this study's participants: that money was not seen to be a contributing factor to one's own health status.

Clearly, the relationship between income and health promotion/health is a very complex one which must be explored further. Discussions with the present group of senior women living on limited incomes appears to support the contention that income has the potential to impact health promotion: directly through the limitation of social support (phone calls, visits), recreation, personal services and supplies (e.g. affordability of clothing & food), health care costs and indirectly through lack of

transportation. Despite this, a number of the senior women in this study stated that their health status was not related to their low income.

Poverty or low income level has been widely seen as one of a number of socio-environmental determinants of health (Canadian Public Health Association, 1996). Recent attention, however, has focused not on the amount of wealth, but rather, it's relative distribution within societies as that which impacts health status (Hamilton & Bhatti, 1996; Wilkinson, 1996). It has also been stated that "... money **per se** may be less a health determinant in its instrumental use - to purchase commodities - than in its psychological interpretation as social status or relative importance" (Wilkinson, cited in Labonte, 1993, p. 56). The relationship between low income and health status therefore, does not appear to be a clear, direct association. It is of no surprise then, that some of the women in this study did not believe that their income directly affected their health though it was seen to influence health promotion. Most of these women have likely not been shown any evidence over the course of their daily lives that their low income is correlated or even causes them to develop cancer or become depressed. Such a relationship may only be seen by those conducting the research rather than by those whose lives are affected by these social circumstances.

Definitions of income and health used by quantitative researchers are likely quite different from the definitions of health put forth by participants in this study. Put simply, health and income have different meanings for different people. The personal meaning attributed to income was evident early on in the project when women whose income was often close to the poverty line were excluded from the present study as

they stated that they did not live on a limited income. Perhaps for some women, the negative connotations that are associated with being labelled as 'low income' are too great to face. However, those who admitted to living on a low income, did not appear to dwell on what was missing. Rather, these women seemed to have accepted their present circumstances while trying to make the best of what life could offer.

The meaning of health is also very personal. As discussed earlier, nearly all of the women in this sample stated they were healthy despite suffering from a variety of health problems at the time of the interview. Health was defined in terms of 'independence, happiness, wellness and activity' by these participants. This contrasts greatly with the indicators of health (mortality and morbidity) still common in research studies today (Tarlov, 1996). In the end, we must be content with the possibility that personal experience and personal meaning are conditions which likely mediate the health/income relationship.

Implications for Nursing Practice

The findings from this study point to a variety of implications pertaining to nursing. First, the model, *Health Promotion as Self Nurturance,* clearly demonstrates the wide variety of ways senior women living on limited incomes currently promote their own health. Nurses and other health professionals need to expand their notion of healthy living activities beyond what has traditionally been considered as health promotive (exercise, nutrition). Health promotion, therefore, may include enabling senior women living on limited incomes to maintain personal interests, helping them to stay or become active in their communities, as well helping them to explore the

emotional/spiritual dimensions of health. As stated earlier, one of the participants in this study suggested that nurses be involved in helping seniors to become more politically active within their communities. This reflects a very non-traditional approach to health promotion for nurses but one which will become increasingly important as threats to the Canada Health Act continue to surface and members of the public become disenchanted with those currently holding power.

Nurses must ensure that they do not fall into the trap that all - too - often accompanies working with individuals on limited incomes: that of imposing their middle class values and beliefs on the clients they are working with. Health promotive activities for seniors are often thought of as activities such as traveling, attending a local gym or taking university retirement courses. Thus, there may be a tendency to overlook other healthy ways of living, such as those described by many of the women in this study, or those whose costs are minimal.

Nurses must also re-examine their stereotypes of senior women who live on limited incomes. Feminists and those who advocate for seniors have, for some time, challenged society's image of the aging woman as being old, unattractive and non-productive and have called for an acknowledgment of senior women's strengths. "Understanding the possibility that an older woman perceives herself as strong, instead of assuming that she sees herself as weak, changes the ways in which nurses assist others" (Moloney, 1995, p. 108). Although the women in this study were lacking in finances, their resiliency and resourcefulness brought to light what nurses need to assess for and build upon when working with such populations. Nurses are encouraged

to utilize conceptual models such as the McGill Model of Nursing to guide their nursing practice. This model focuses on the nurse's recognition of the client's strengths, potential, and personal resources while at the same time engaging in a relationship with the client that is collaborative in nature (Gottlieb & Rowat, 1987). It is by focusing on what low income senior women have rather than what they don't have, that empowerment, considered to be a central tenant of health promotion today (Rootman & Goodstadt, 1996; Muller, 1988), can be attained.

Efforts must be made to increase the health promotive services offered to low income senior women by community health nurses. It was not surprising to find that the primary health care professional cited by most of these women in relation to health promotion was their family doctor, followed by nurses. In both cases, services which were focused on disease prevention were described most frequently. Only one of the participants spoke of working in partnership with a public health nurse and other members of the community in promoting health. This is not surprising when only four public health nurses are employed by this large Canadian city to work exclusively with seniors. In other areas of Canada, public health work is restricted to work with young families. Clearly, the time has come for public health nursing to expand its scope of practice to include members of the community from all age groups.

Finally, the results of this study support the notion that health promotion must be addressed from both the socio-environmental and behavioral approaches. These women's stories have reinforced the belief that health promotion does not occur in a vacuum (Backett, 1988), rather, it is often influenced by the social context in which it

occurs (i.e. living on a limited income). On the other hand, the personal experience of health promotion cannot be overlooked despite fears that solely attending to health promotion at the individual level will 1) be biased to the middle class, 2) will undermine the importance of social change and 3) will contribute to 'victim blaming' by the powers that be (Green & Raeburn, 1988; Catford, 1993; Lowenberg, 1995; Kickbusch, 1989; Hamilton & Bhatti, 1996). Many authors have called for a renewed amalgamation of both the social and personal dimensions of health promotion (Kickbusch, 1984; Delaney, 1994; Robertson & Minkler, 1994; Green & Raeburn, 1988; Slater & Carlton, 1985; Sharpe & Mezoff, 1995) and the findings of this study reinforce the importance of intervening at both these levels. Nurses are obliged to be mindful of this balance when helping to promote health in the years to come.

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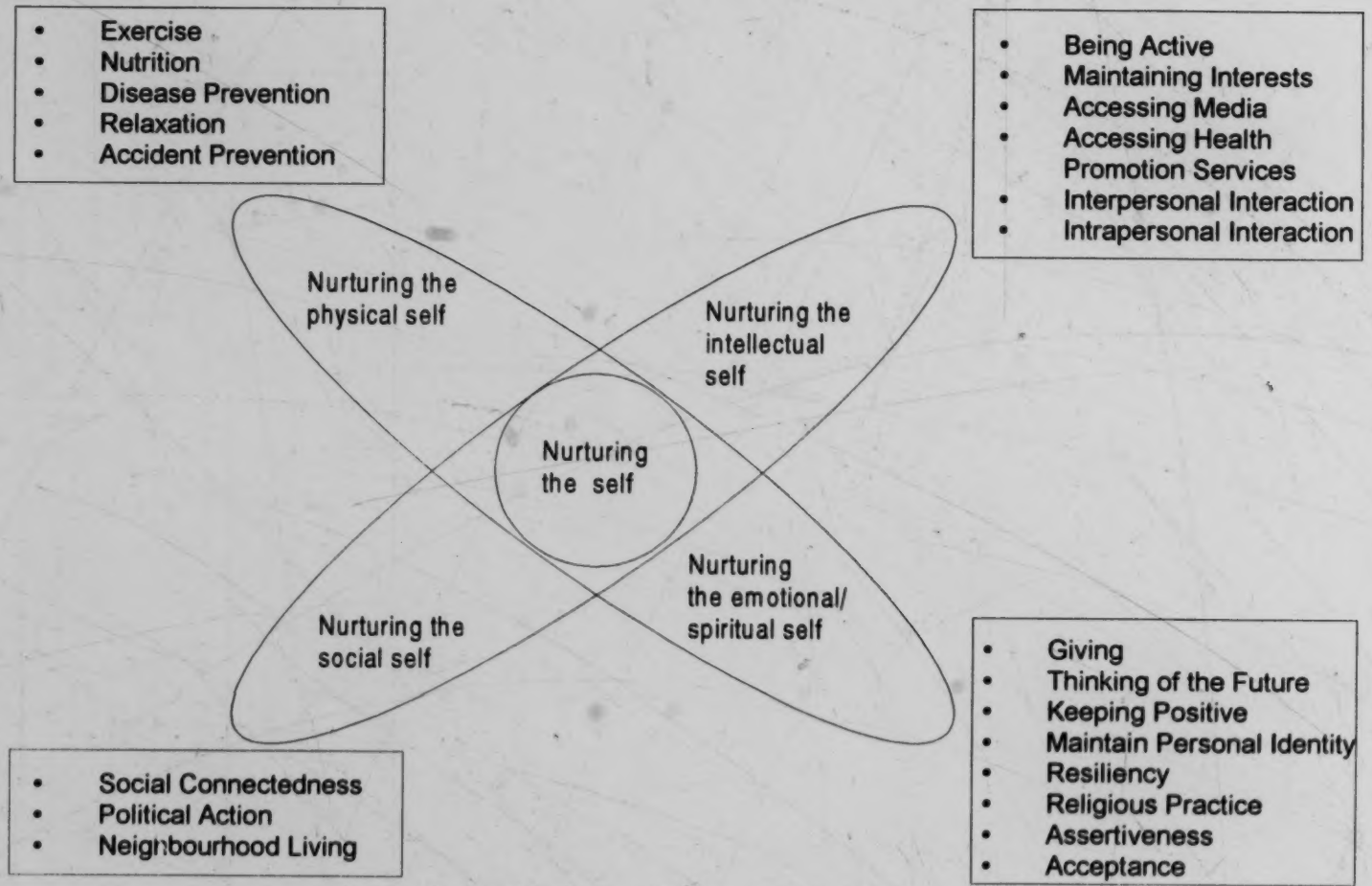

Figure 1. Health Promotion as Self Nurturance

Appendix A

Information Sheet on Health Promotion Study of Women
Drop-In Centre Clients

My name is Heather Morris and I am a nurse who is studying how senior women maintain and improve their own health. I am interested in talking with senior women who are living on limited incomes. This study will take place over the next six months. During that time, I would like to interview you on one or two separate occasions. I hope that the information from our talks will help other professionals who work with senior women.

The interviews will be tape recorded, will take about one hour each and can take place where you prefer. Your decision to take part in this study will not affect the care you receive from the senior centre, your doctor or your nurse. The information you share with me will only be read by me, my supervisor, the secretary and one or two other faculty members. We will be the only persons to know your name.

All tapes, notes, the codebook, typed interviews and forms will be kept in a locked filing cabinet that only I have a key for. The codebook that contains your name and address and consent form will be locked in a separate place. All information will be locked up for at least seven years before it is destroyed. If the typed interviews are used for another study in the future, permission will be obtained first from an ethics committee.

Your name will not appear in any papers or talks about the study. Some of your statements will likely appear in papers or talks about the study but I will not use your name and I will do all that I can to keep your identity a secret.

If you are interested in taking part in this study, please call me at 492-6251 or tell ____. Then we can make an appointment to meet for the first interview. You can call me if you have any questions at the same number. Please leave a message on the answering machine or with the secretary. I will call you back as soon as I can.

Thank you.

Heather M. Morris RN BN
Master of Nursing Student
Faculty of Nursing, University of Alberta

Appendix B

Information Sheet on Health Promotion Study of Women
Public Health Nurse Clients

My name is Heather Morris and I am a nurse who is studying how senior women maintain and improve their own health. I am interested in talking with senior women who are living on limited incomes. This study will take place over the next six months. During that time, I would like to interview you on one or two separate occasions. I hope that the information from our talks will help other professionals who work with senior women.

The interviews will be tape recorded, will take about one hour each and can take place where you prefer. Your decision to take part in this study will not affect the care you receive from your doctor or your nurse. The information you share with me will only be read by me, my supervisor, the secretary and one or two other faculty members. We will be the only persons to know your name.

All tapes, notes, the codebook, typed interviews and forms will be kept in a locked filing cabinet that only I have a key for. The codebook that contains your name and address and consent form will be locked in a separate place. All information will be locked up for at least seven years before it is destroyed. If the typed interviews are used for another study in the future, permission will be obtained first from an ethics committee.

Your name will not appear in any papers or talks about the study. Some of your statements will likely appear in papers or talks about the study but I will not use your name and I will do all that I can to keep your identity a secret.

If you are interested in taking part in this study, please call me at 492-6251 or tell your public health nurse. Then we can make an appointment to meet for the first interview. You can call me if you have any questions at the same number. Please leave a message on the answering machine or with the secretary. I will call you back as soon as I can.

Thank you.

Heather M. Morris RN BN
Master of Nursing Student
Faculty of Nursing, University of Alberta

Appendix C

Information Sheet on Health Promotion Study of Women
Outreach Worker Clients & Lodge Clients

My name is Heather Morris and I am a nurse who is studying how senior women maintain and improve their own health. I am interested in talking with senior women who are living on limited incomes. This study will take place over the next six months. During that time, I would like to interview you on one or two separate occasions. I hope that the information from our talks will help other professionals who work with senior women.

The interviews will be tape recorded, will take about one hour each and can take place where you prefer. Your decision to take part in this study will not affect the care you receive from the senior centre, your doctor or your nurse. The information you share with me will only be read by me, my supervisor, the secretary and one or two other faculty members. We will be the only persons to know your name.

All tapes, notes, the codebook, typed interviews and forms will be kept in a locked filing cabinet that only I have a key for. The codebook that contains your name and address and consent form will be locked in a separate place. All information will be locked up for at least seven years before it is destroyed. If the typed interviews are used for another study in the future, permission will be obtained first from an ethics committee.

Your name will not appear in any papers or talks about the study. Some of your statements will likely appear in papers or talks about the study but I will not use your name and I will do all that I can to keep your identity a secret.

If you are interested in taking part in this study, please call me at 492-6251 or tell ____. Then we can make an appointment to meet for the first interview. You can call me if you have any questions at the same number. Please leave a message on the answering machine or with the secretary. I will call you back as soon as I can.

Thank you.

Heather M. Morris RN BN
Master of Nursing Student
Faculty of Nursing, University of Alberta

Appendix D

Informed Consent Form

Title of Project: Health Promotion as Described by Inner City Senior Women

Researcher: Heather M. Morris, RN BN
MN Candidate
Faculty of Nursing, University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, AB T6G 2G3
492-6251

Supervisor: Dr. Janet C. Ross Kerr
Professor, Faculty of Nursing
Faculty of Nursing, University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, AB T6G 2G3
492-6253

The purpose of this study is to describe how inner city senior women maintain and/or improve their own health. This study will take place over the next six months. During that time, I will interview you on one or two separate occasions for about an hour each time. During the interviews, I will ask you questions about how you maintain and/or improve your health. I may also ask you for your opinion on what I have found out so far in this study. These interviews will be tape recorded and will take place where you want. I hope that the information from our talks will help other professionals in helping senior women.

Your decision to take part in this study will not affect the care you receive from any senior centres, your doctor or your nurse. The information you share with me will only be read by me, my supervisor, the secretary and one or two other faculty members. We will be the only persons to know your name. All tapes, notes, the codebook, typed interviews and forms will be kept in a locked filing cabinet that only I have a key for. The codebook that contains your name and address and the consent form will be locked in a separate place. All information will be locked up for at least seven years before it is destroyed. If the typed interviews are used for another study in the future, permission will be obtained first from an ethics committee.

Your name will not appear in any papers or talks about the study. Some of your statements will likely appear in papers or talks about the study but I will not use your name and I will do all that I can to keep your identity a secret.

You do not have to be in this study if you do not want to be. If you only want to be in part of the study, that is okay. You can drop out of the study at any time by telling the researcher or _____. You can choose not to answer any questions. You will not receive any direct benefits or be at any risk if you choose to be in the study.

_____

I, _____ have read or listened to this consent form and agree to participate in the study. I agree to being interviewed on one or two separate occasions.

I have been asked if I have any questions and have had them answered to my satisfaction. I know that a copy of this consent form will be given to me today. I can call Heather Morris to ask any questions or discuss any matters at the phone number listed above.

_____ Date

_____ Signature of Participant

_____ Signature of Researcher

I would like a copy of the results of this study in the future:

Name:_____
Address:_____
_____
_____
_____

Appendix E
Biographic Data

Code No. _____

1. Age _____

2. Marital Status:

Married	_____
Widowed	_____
Single	_____
Divorced	_____
C/L	_____

3. Place of Residence: _____

4. Country of Birth: _____

5. Living Situation (Homeowner/Renting): _____

6. Number of Children and Location of Children: _____

7. Highest Level of Education Attained: _____

8. Present/Past Employment: _____

9. Current Health Problems/Health History: _____
_____
_____
_____

Appendix F

Guiding Questions for Participant Interviews - Round 1

The following are examples of guiding questions which may be asked over the course of one or two interviews with senior women living in poverty. These questions may not be asked if participants have already answered them in the course of discussion. Other questions may be added to this list as the study proceeds. I will begin the interview by asking the questions on the demographic form, followed by the three general questions listed below. This will be followed by more specific questions later on in the interview.

1. Do you think you are healthy? Why or why not?
2. Tell me in your own words what health means.
3. What do you think of people who work to stay healthy or improve their health?
4. Have you done anything to help yourself stay healthy or improve your health? If so, what?

----5. How important is it to try to stay healthy or improve your health? How come?

6. Do the kinds of things you used to do to stay healthy or improve your health when you were younger differ from what you do now? If yes, how so?
7. Do you know any other people who work at keeping themselves healthy or improving their health? If yes, describe them to me.
8. What things influence whether you are able to work at staying healthy or improving your health? Which are the most important of things?

9. What or who motivates you to work at staying healthy or improving your health?

10. Do you give advice to other people about how to stay healthy or improve their health? If yes, what?

11. Would you say that you are a person who lives on a limited income? May I ask you what you think your total yearly income before taxes are taken off is?

12. Does your income in any way affect what you do or don't do in trying to stay healthy or improving your health?

12. Is there anything else you would like to say about this topic.

Guiding Questions - Round 2

A: Validation of Information from Previous Interview

B: Questions

1. HEALTH PROMOTION

a) We talked before about how it is that you maintain or improve your health and you said _____. Are there any more things that you want to tell me?

2. INCOME

a) What is your source of income?

b) What is it like to live on a low income?

c) Have you always lived on a limited income?

3. ENVIRONMENT

a) Tell me what it is like to live in your neighborhood. Do you like it?

b) Is it good for your health to live in this neighborhood? Does living here affect how you maintain or improve your health?

4. WOMEN/CULTURE

a) One woman I spoke to talked about how her life experience is different from what a senior man might have experienced? (e.g. lower education). What would you say to that?

b) Some people say that their ethnic background affects how they maintain or improve their health? Would you say this is true for you?

5. SERVICES

a) Can you tell me about some services that help seniors maintain or improve their health?

b)Do you access any services for seniors? Tell me about them. Do they help you to maintain or improve your health?

c) Do you want help from professionals in improving/maintaining your health?

d) Have you encountered any nurses that help you maintain or improve your health? If yes, tell me about it.

e) Are there special services nurses/professionals can offer to limited income senior women to help maintain or improve their health?

f) What do nurses need to remember when planning health programs for low income senior women?

g) Is there anything else you want to say?